Policy issues affecting the provision of medical care within correctional institutions

by

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POLICY ISSUES AFFECTING THE PROVISION OF MEDICAL CARE WITHIN CORRECTIONAL INSTITUTIONS

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During the last decade, the provision of medical care within correctional institutions (prisons and jails) has come under close scrutiny by organizations (American Medical Association, American Public Health Association, American Correctional Association); funding agencies (Law Enforcement Assistance Administration); practitioners-researchers; and Federal and State courts. The basic conclusion from all this observation was that correctional institutions provide inadequate medical care to their captive populations.

In Delaware, the problems surrounding the provision of medical care within correctional institutions are similar to those faced in other States. Unfortunately, because of Delaware's size (the small geographic area allowing more face-to-face confrontation) and its historical propensity for political rivalry, the problems often take on the appearance of insurmountable obstacles.

The purpose of this report is to: (1) summarize National policy trends affecting the provision of medical services within correctional institutions; and (2) review Federal Court decisions pertaining to medical care and the constitutional rights of offenders.
I. FEDERAL STRATEGIES IN HEALTH CARE

During the 1950's, the National Institute of Health (NIH) was created under the Department of Health, Education and Welfare (DEW) as a resource to finance and stimulate biomedical research. Decker (1977) maintained that shortly thereafter, a partnership between academic medicine and NIH resulted in an effective lobby for annual increases in the Federal allocations to biomedical research. During FY 1979, NIH received $916.8 million for health research and an additional $484.9 million for training and education of health care professionals.

The consequences of this Federal program were summarized as follows:

- Massive increases in medical technology during the 1950's-1970's with corresponding increases in the cost of medical care;
- Increased specialization and sub-specialization of health care personnel and a depersonalization of medicine; and a resulting overspecialization in a largely disorganized medical care system with corresponding difficulties in both patient access to care and continuity of treatment.

Somers (1971) noted that the increasing proportion of specialists has reduced the number of doctors available for general medical care. During 1970-1971, only 2% of all medical students were considering going into general practice. Somers concluded that while there were "more and better trained doctors," an "increasing imbalance between supply and demand" produced "emotional and financial pressures, resentment on part of both doctors and patients, and public deprecation of the medical profession."

But how has over-specialization affected the provision of medical services within correctional institutions? Goldsmith (1975) maintained that the adoption of technical expertise and the resulting specialization has created severe problems in recruiting physicians to practice medicine as general practitioners in rural America, the ghetto areas and correctional institutions. The most obvious problem is the provision of primary medical care which requires the use of general practitioners. But "being a general practitioner means not being a specialist - an expert."

According to Goldsmith:

A typical day for a prison physician involves physicals, sick-call and, possibly, an actual emergency. Physical examinations, as a regular routine, tend to be unrewarding. Asking the same questions and performing the same simple procedures is not very intellectually challenging. Sick-call in prison is conceptually similar to the practice of general medicine in the free world - with several major variations. First, patients on the outside normally are not in the physician's office because they are seeking to alleviate their boredom, get drugs for sale, or perhaps arrange a trip to another part of town. Second, patients in the free world have and exercise the option of self-medication, a privilege not available to inmates. Thus, conditions such as gastric upset, headache, or perhaps hemorrhoids, which are often treated by an individual with over-the-counter drugs, must become a Medical Department encounter. In addition, the prison physician is put in the uncomfortable position of having to legitimate illness or injury so that the inmate can be excused from his normal activities.

The author maintained that over-specialization and the routine problems/complaints encountered in delivering primary medical care constitute a major constraint on
delivering health services within correctional institutions.

This trend is evident in the State of Delaware. In Sussex County, the only mechanism for providing health services to inmates at Sussex Correctional Institution (SCI, an adult male facility) is the transportation of inmates to a local hospital. Services are provided on a contractual arrangement with a hospital's physician. Efforts to secure a physician to work within SCI have been unsuccessful.

According to a recent consultants' report, A Plan for Standard Health Care Services at Delaware Correctional Institutions, no licensed physician was on-call at Women's Correctional Institution (WCI, New Castle County, Delaware). During the time of this survey (March-April, 1977), the physician on-call had passed his boards but was not then licensed to practice medicine in the State of Delaware. This physician subsequently resigned and the Department of Correction has attempted to fill this position. (These efforts may be rewarded within the next two months, assuming that the applicant does not find a more lucrative position during the interim period.)

The second major Federal strategy having direct impact on the provision of medical services within jails and prisons concerns the funding of groups and organizations to develop standards of acceptable minimal levels of medical services. The intent of such a process is to develop standards which can be applied through the application of internal auditing procedures, i.e., correctional agency self-evaluation. This process has been termed by Sechrest (1976) as the "accreditation movement in corrections" and has involved such groups as: the American Medical Association (AMA); the American Public Health Association (APHA); the Law Enforcement Assistance Association (LEAA); and the American Correctional Association (ACA).

The LEAA has funded (or provided initial funding) for efforts establishing three sets of medical/health care standards. During the first few months of 1976, LEAA awarded a two-year grant ($448,000 annually) to the AMA for the development of medical standards. The intent of the project was to:

- Develop standards for medical, dental, mental health and alcohol and drug rehabilitation services offered to inmates;
- Test these standards in 30 jails within Indiana, Maryland, Michigan, Washington and Wisconsin.

The ultimate goal of this project is to "establish a formal certification system for jail medical programs," i.e., a National health accreditation program for correctional institutions.

The second LEAA funded project led to the development of a prescriptive package entitled Health Care in Correctional Institutions, and was used by LEAA as the basis for a discretionary grant program during FY 1978. The third project was a grant from LEAA to the American Correctional Association for the creation of the Commission on Accreditation. The Commission has reviewed many existing standards of services, approximately 40-50 of which apply to the provision
of medical/health care within correctional institutions.
A fourth set of medical standards has been proposed by the
American Public Health Association. A cross-tabulation of
all four sets of standards has been included as Appendix A
to this report.
Two comments relate to this Federal strategy of funding
standards/accreditation efforts: (1) considering that the
AMA, APHA and ACA are currently holding (and attending)
seminars to encourage endorsement of their particular standards,
one might question the wisdom of financing the creation of
four separate and distinct guidelines (standard) sets; and
(2) the major problem with standards development and subse-
quent implementation via a self-evaluation accreditation
process is one of "uniform and systematic application." II.
FEDERAL COURT DECISIONS
The normal statutory route for inmates alleging viola-
tion of their constitutional rights is to sue under the Civil
Rights Act (42 U.S.C. § 1983) which states:
Every person who, under color of any statute,
ordinance, custom, or usage of any State or Territ-
ory, subjects or causes to be subjected any citizen
of the United States, or other person within the
jurisdiction thereof to the deprivation of any
right; privileges, or immunities secured by the
Constitution and laws, shall be liable to the party
injured in an action of law suit in equity, or other
proper proceeding for redress.
In complaints involving medical services and treatment,
the usual constitutional provisions relied upon are the
Eighth ("cruel and unusual punishment") and Fourteenth
("due process") Amendments.
Holder (1971) stated that successful suits against prison
officials exhibited the following elements:
• An acute physical condition in existence;
• The obvious need for urgent medical care;
• A failure to provide it; and
• A tangible residual injury resulting from this failure.
An example of such a case was Williams vs. Vincent.
(508 F. 2d, 541, 1974, ref: 11 CLB 508):
State prisoners pro se complaint alleged that after
a portion of his ear had been severed by another pris-
oner, hospital personnel refused his request to try
to suture ear back on but threw it away instead, saying
that he did not need his ear. The prisoner further
alleged that when he protested this treatment, he was
placed in solitary confinement for 22 days without any
medical attention.
The Second Circuit held that the complaint stated
a cause of action for deprivation of Civil Rights. "A
complaint under Section 1983 (Civil Rights Act) based
on inadequate medical treatment states a cause of
action if it alleges conduct which shocks the conscience;
such as deliberate indifference by prison authorities
to a prisoner's request for essential medical treatment.
'On the basis of the allegations in the complaint, the
possibility that deliberate indifference caused an
easier and less efficacious treatment to be consciously
chosen by the doctors cannot be completely foreclosed.'
During the late 1960's through early 1970's, Federal
courts usually applied a "hands-off" doctrine to prisons.
Suits alleging negligence or mal-practice were handled in
State courts; thus, the Federal courts assumed that an inmate
was not left remediless. For example, the court in Ramsey
vs. Ciccone (310F Supp. 600, DC Mo 1970) wrote:
Improper or inadequate medical treatment in order
in order to constitute cruel and unusual punishment must be
continuing, must not be supported by any competent
school of medical practice and must amount to a
denial of care. (There is a duty to provide medical
care.) Simple negligence is not a denial of care but
is a tort that can be compensated. Gross negligence
may be equated with damage intentionally inflicted
and is an Eighth Amendment violation.
By 1972, Federal courts showed increased concern with correctional policies that violated inmates’ constitutional rights. During 1975, Federal courts repudiated the “hands-off” doctrine and began to critically evaluate correctional administrative policies and procedures. For example, the court in *McCray vs. Burrell* (516 F.2d 357, 4th Cir. 1975) held that:

State prisoners claiming deprivation of civil rights in prison treatment were not required to exhaust available State administrative or judicial remedies before a Federal District Court could exercise jurisdiction in a suit brought under 42 U.S.C. § 1983. It was not, moreover, necessary for plaintiffs to show that the State did not provide an effective administrative remedy for their claims.

In addition, Federal courts have modified their concern in medical claims from “denial of treatment” and “gross negligence” to the adequacy of treatment itself. For example, in *Newman vs. Alabama* (349 F. Supp. 274, M.D. Ala. 1972) the court ruled that: medical care was not adequate; the Alabama Department of Correction had violated inmates’ constitutional rights guaranteed under the Eighth and Fourteenth Amendments; and ordered specific remedial actions. The court ordered Alabama to implement Federal standards for Participation of Hospitals in the Medicare Program (Order of October 4, 1972 at p. 1).

Two corollary issues have been raised in Federal court decisions pertaining to medical treatment within correctional institutions. The first issue concerns the physician’s duty to inmate patients. In *Piscano vs. State* (8 App. Div. 335, N.Y.S. 2d 35, 39, 1965), the court stated that:

Prison physicians owe no less duty to prisoners who must accept their care than to private patients who are free to choose . . . . Sound medical judgment results from a fair and uninfluenced analysis and determination based only on physical condition and needs . . . not on extraneous factors . . . certainly not on the inflexibility of the budget.

The second corollary issue concerns the State’s responsibility for providing medical treatment to indigent offenders. Plotkin stated:

“At present there are no reported decisions on this point, although there are indications (e.g. *Piscano vs. State*) that courts will require the State to bear at least moderate expenses for reasonable treatment.”

These corollary issues directly impact on the extent of Delaware’s compliance with Civil Action 74-179 (*Preston et al. vs. Keva et al.* U. S. District Court for the District of Delaware, April 19, 1976). The plaintiffs alleged that the physical structure (and medical services) provided at Sussex Correctional Institution violated their constitutional rights under the Eighth and Fourteenth Amendments. In his final order, Judge Murray M. Schwartz stipulated 126 actions that the Delaware Department of Correction must undertake. Twenty of these stipulations related to medical care/sanitation. (These stipulations, as well as the extent of compliance as of April, 1977, are included as Attachment B to this report).

One year after the final order (C.A. 74-179), several violations were noted in a consultants’ survey of existing correctional medical services: failure to close/remodel the infirmary; failure to provide in-house physician services; failure to provide medical attendants to dispense medication;
failure to isolate new commitments until intake physicals are completed and laboratory tests are analyzed; and failure to provide all inmates with physical examination. 25

The major reasons advanced by the Delaware Department of Correction for non-compliance with the April, 1976, court order were: (1) inadequate budget; and (2) construction/renovation delays. As to the "inadequate budget," the legal precedent established in Piscano vs. State appears to repudiate such a defense. However, clarification of the State's responsibility in providing indigent offenders with "adequate" medical care should occur before the Department of Correction and the State of Delaware would fully warrant Contempt of Court violations. Compliance with the stipulation to provide in-house physician services is a difficult task considering the impact of the NIH program (and subsequent lack of general practitioners) outlined in Section I of this report. Such clarification may occur as a result of a brief filed September 23, 1977. This class action suit was filed on behalf of the inmates of Women's Correctional Institution (WCI) by the Community Legal Aid Society. The complaint (to be heard in February, 1978) contends that the "defendants' policies and practices deprive inmates of their constitutional rights under the First, Fifth, Sixth, Eighth and Fourteenth Amendments to the United States Constitution. 26 Specific relief was requested for charges ranging from lack of medical care to overcrowded conditions and discrimination in programming.

III. ADDENDUM: INFORMATION OBTAINED AT THE REGION III SEMINAR.
"HEALTH CARE IN CORRECTIONAL INSTITUTIONS," SEPTEMBER 28-30, PHILADELPHIA, PA.

A fifth set of national healthcare standards (the fourth funded by LEAA, or its research arm - the National Institute of Law Enforcement) is being developed by a "Special Committee on Uniform Corrections Code" (SUCC) of the National Conference of Commissioners on Uniform State Laws. SUCC is drafting a medical section in the proposed "Uniform Corrections Act."

LEAA will be evaluating all health care standards in an attempt to promote one distinct set applicable to all correctional institutions. Arno (1977) has summarized the potential impact of health care standards on correctional institutions:

Standards in and of themselves are not an effective source of change. Without some additional mechanism to guage or force compliance, there is nothing to ensure that standards will be implemented by correctional institutions... while LEAA cannot force others to adopt the standards it selects, adherence can be effectively controlled by withholding federal funds from institutions and agencies that choose not to comply. Accreditation seems to be the wave of the future. (emphasis added) 27

In addition, Arno stated that once a particular set of health care standards were officially recognized, "these standards will also be the ones mandated by most, if not all, of the courts." 28

In Section II of this report, aspects of federal court decisions discussed were: the nature of complaints involving medical services filed under the Civil Rights Act; trends in court intervention in the administration of correctional institutions; the physician's duty to inmate patients; and the State's responsibility for providing medical treatment to indigent offenders. Additional
information concerning recent court decisions that address the
primary issue - the State's responsibility for providing medical
treatment to inmate captive populations (regardless of a condition
of being "indigent") - has been summarized by Isele. For example,
a 1976 Supreme Court decision affirmed that denial of medical care
to inmates constituted cruel and unusual punishment:

(The) principles (behind the guarantee against cruel and unusual punishment) establish the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, these needs will not be met. Estelle v. Gamble, 97 S. Ct. 285 (1976)."35

Though it might be argued that the provision of medical treatment to inmates is an additional benefit that might not have been available to him while in residence within his community, one court has maintained:

An individual incarcerated...becomes both vulnerable and dependent upon the State to provide certain simple and basic human needs....Denial of necessary medical attention may well result in disabilities beyond that contemplated by the incarceration itself. Restrained by the authorities of the State, the individual cannot himself seek medical aid or provide the other necessities for sustaining life and health. Pate v. Shanbell, 468 F. 2d 1076 (emphasis in original)."31

Finally, Isele maintained that many courts have determined that budgetary constraints are not defenses for insufficient (inadequate) medical care. 32

The court decisions reviewed in this paper have left unanswered several critical questions: "must every 'medical' need be met, including elective or cosmetic procedures? If not, to what extent must medical care be provided?"33 Thus, an officially recognized definition of "adequate" or "essential" medical care (perhaps via adoption of a single set of health care standards) is needed so that correctional agencies, inmates, judges and the public at large will be able to evaluate medical services within prisons.
23. Ibid, pp. 165-166.
33. Ibid, p. 63.

BIBLIOGRAPHY WITH SELECTED ANNOTATIONS


American Correctional Association, Proposed Standards for Adult Long-Term Institutions, Commission on Accreditation for Corrections, draft, July, 1977: The CAC has proposed 26 standards for medical and health services. Standards are rated according to their relative importance ("essential" or "important"). In all probability, this set of standards will be the ones selected by LEAA as officially recognized guidelines for a national accreditation program. CAC used consensus building among representatives of a number of recognized groups in corrections to determine both the standards and the nature of its proposed accreditation program.

American Medical Association, Standards for the Accreditation of Medical Care and Health Services in Jails, draft, undated: Areas of medical care in jails, including administrative structures, hygiene and food service. In addition, a glossary of key words was provided to give definitions of key words appearing in the standards. Such words as "adequate," "acceptable," and any other word that is used to describe the quality of medical care are open to interpretation. These standards must need to be strengthened to facilitate accurate evaluations of jail's medical care.

American Public Health Association, Standards for Health Services in Correctional Institutions, Task Force, 1976: APHA has provided standards relating to eleven areas of public health care, each area lists series of principles, the compliance. As in the case of the CAC standards, terms are open to ideal levels of services (for example mental health which is determined by the treating physician).
Arno, B. J., "Standards for Health Care in Correctional Institutions," in Norma B. Gluckstern, Margaret Keuse, Jay Harnes, Ralph Packard, and Cecil Patson (eds.), Health Care in Correctional Institutions: Participant's Handbook, Washington University Research Corporation, 1971. This paper provides: a brief history of the standards setting process; discussion of the ADA, ACA(CAC), APHA and NSA (National Sheriffs' Association) standards on medical care; and notes current problems and potential future trends in the standard setting/creditation movement. Finally, NSA and ADA standards are compared in a table similar to that provided in Appendix A to this report.

Anzel, D.M., "Medical Care in Three Prisons in California," American Journal of Corrections, Volume 29, #6 (Nov.- Dec., 1967), pp. 13-15. - This study indicated that although the beds were not conducive to rest, all the hospitals gave intake physical examinations, including X-rays, urine analysis, and psychological testing. The major recommendation of this study was that an appropriate staffing ratio (physicians to inmates) was 1:500.

Brecher, Edward M. and Della Penna, Richard D., Health Care in Correctional Institutions, Washington: U.S. Department of Justice (DOJ), September, 1975. - This "prescriptive package" was organized in three parts: medical services; organization; and "other considerations." Including dental care, interpersonal relationships among staff and environmental considerations. As such, discussion centered around the rationale for suggested services and not clearly defined standards. However, the major elements of the topics discussed were presented in the form of standards in Appendix A to this report.

Buffum, Peter C., Prison Medical Services in the Greater Delaware Valley, Philadelphia: Pennsylvania Prison Society, June, 1976. - This report represents the results of a brief survey of prison health care policies observed in four area county jails. The major considerations were: (1) procedures should be developed for inmate health care complaints and suggestions; (2) health education courses should be provided to inmates; (3) greater information sharing on prison medical services should occur; and (4) increased monitoring (via outside agencies) is needed.

Goldsmith, Seth B., "Jailhouse Medicine - travesty of justice," Health Services Research, Vol. 4, No. 9 (Nov., 1972), pp. 767-77. This author reported the results of his epidemiologic study done in 1971. Though no major medical problems were found, 12% of the men might have had an active urinary tract infection, and an addi- tion of the medical personnel records of these inmates revealed that none had been previously seen for either of these infections. In addi- tion, two weeks after the prison hospital received the abnormal treatment or followup laboratory work.


Goldsmith, Seth B., Prison Health - Traveesty of Justice, New York: Prodist, 1975. - In this book, the author combines/expand earlier studies referenced above to present an overall view of the medical care, constraints among prisons are discussed. Several case studies and "vignettes" are provided to elaborate a reasonable quantity of comprehensive services are not available; need to be installed; professionally trained medical staff are "contracting-out" or massive reorganization are needed coupled with rational allocation of health care resources.

Hoffler, Angela R., "Law and Medicine: The Prisoner's Right to Medical Treatment," American Journal of Corrections, Vol. 33, the APA, Vol. 216, No. 7, May, 1973, pp. 1253-1254. - The courts concluded: (i.e., prison administrators obviously sick prisoner); (ii) once care was prescribed, usually held to be within the discretion of administration (as civil rights violations).


Iselle, William F., "Constitutional Issues of the Prisoner's Right to Health Care," in Norma B. Gluckstern, Margaret Keuse, Jay Harnes, Ralph Packard and Cecil Patson (eds.), Health Care in Correctional Institutions: Participant's Handbook, Washington University Research Corporation, 1971. - This paper noted court decisions that were based on the premise of "essentials" or treatment are explored. Many of the author's contentions were not trends in judicial intervention into the prisons' administration of medical services.
- The author reported medical and health data on all adult male prisoners, parolees and probationers in the custody of Tenn., correctional authorities from January 1972 through June 1973. Indicators of health reported were mortality, morbidity, disability and emotional distress. Treatment indicators used were outpatient diagnoses and treatment, hospital episodes, surgical operations and convalescence. The major goal of the study was to test a methodology for estimating the relative health risks (dangerousness) of (1) life within the Tennessee State Penitentiary compared to (2) life within the world outside. Results of this study were: prisoners reported most varieties of morbidity conditions at much higher rates than did parolees or probationers (including acute morbidity conditions); prisoners under 25 years old were most likely to become victims of homicide or heterosexual rape; prisoners confined for 30 years or less than one year reported acute physical conditions at substantially higher rates than did other prisoners (especially in the case of prisoners serving over 10 years, but denied parole). 16.5% of the prisoners were diagnosed as exhibiting symptoms of an acute personality disorder (5.6% of these inmates had received their first psychiatric examination during their term of imprisonment; and that many self-destructive prisoners exhibit behavior similar to "hospital addicts" having the "Funchausen Syndrome." Therefore, imprisonment appears to penalize the health of different classes of inmates in separate and distinct ways, and in various degrees.

King, Lambert, Joynolds, Arlene and Young, Quentin. "Utilization of Former Military Corpsmen in the Provision of Jail Health Services." American Journal of Public Health, Vol. 67, No. 8 (August, 1977), pp. 730-734. This paper reports on the use of military corpsmen within the Cook County (Illinois) Department of Corrections. Corpsmen could perform only those functions of corrections that were delegated to them by a licensed physician (such as evaluations, drawing serology samples and other medication). Since the program was initiated, the percentage of medical duties allowed increased from 16% to 65% of the total. The author notes that the utilization of former military corpsmen could be beneficial as long as an adequate support staff (physicians, nurses, etc.) were available.


McBride, Andrew D., Nelson, Lorraine A., Booser, Jacqueline L. and Frey, Gerald T. "Cost Incentives for Establishing Improved County Health Care in a County Prison," Oct., 1976. This report summarized the efforts of the District Office of the Pennsylvania Department of Health in providing technical guidance and health recommendations to the Montgomery County Prison. The District Office reviewed health services provided at the prison analyzed hospital records for expenses and length of stays and interviewed prison staff, hospital staff and inmates. The review of available fiscal records revealed estimated expenditures approximately twice as great as funds formally budgeted for medical services. Estimated expenditures for inmate hospital services accounted for 30-30% of the total medical expenditures for inmates. Hospital guard costs equalled or exceeded the actual hospital bills in 3% of inmate hospital admissions. The consultants recommended that: (1) the management of inmate hospitalization be improved; and (2) County investment for additional on-site health personnel services could pay for itself.

- The consultants were employed to provide a descriptive evaluation of the medical services provided at Delaware's correctional institutions; and compare existing practices to LEAA minimum health care standards. On-site interviews with health care providers were made at all nine correctional institutions. The major medical issues (or problem areas) covered were: "Nature and extent of initial, routine and terminal physical;" "control and dispensing of medication;" "substance abuse diagnosis and treatment;" and "compliance with existing U.S. District Court orders." The consultants concluded that: A Statewide Health Administrator be hired so that medical services could be uniformly upgraded; uniform medical records must be adopted; a screening examination should be carried out at each institution; complete medical histories and physical examinations should be completed within 48 hours of an inmate's admission; a formulary should be created and stocked in a medical dispensary and released only by a medical doctor; medical records and that sufficient medical attendants, nurses and medical records clerks be hired so that in-house medical service could reach LEAA minimum health care standards.

Minnesota Department of Corrections. Determination of Quality of Care in Correctional Institutions, Minneapolis, Minn., 1973.

National Sheriffs. Association. The National Sheriffs Association Manual of Jail Administration, Washington, D.C., 1970 - Chapter XX includes 15 standards relating to health services; newly received inmates should receive a physical examination before assignment to a housing area; services of a physician should always be available; sick call held daily; adequate numbers of health care staff; maximum use of community facilities; carefully supervised distribution of medication; necessary prosthetic devices should be furnished; adequately equipped medical examining room; creation of a separate intake room; training of all health staff; jail kept in good sanitation condition; adequate bathing, washing, drinking and toilet facilities; hair-cutting and shaving facilities; current medical records; and medical treatment should aid in the rehabilitation of prisoners.
Plotkin, Robert. "Enforcing Prisoner's Rights to Medical Treatment," Criminal Law Bulletin, Vol. 9, No. 2 (March, 1973) pp. 159-172. - This author presented his discussion on inmate's rights to medical treatment by addressing the following issues: jurisdiction for state prisoners (federal and state court decisions; jurisdiction for federal prisoners; and litigation issues (individual and class action suits). The article was addressed primarily to lawyers representing inmates. Many of the issues/decisions discussed by Plotkin were included in Section II of my report.


Sechrest, Dale K. "The Accreditation Movement in Corrections," Federal Probation (Dec., 1976) pp. 35-39. - The historical development of the "Accreditation movement" followed three distinct phases: (1870-1939) - basic minimum standards were stated as guidelines for parole boards and services; (1939-1946) - a series of "model acts" were written establishing conditions under which probation and parole could be conducted; (1946-present) - further development of standards coupled with enforcement mechanisms. Standards were and are being produced at an increasing rate. However, the basic problem with standards development has always involved their systematic and uniform application. The author discussed current efforts by the Commission on Accreditation (CAC) to develop an accreditation/self-evaluation process. According to Sechrest, the success of this approach depends on the ability of correctional administrators in using standards to upgrade their correctional systems.


Southern Health Foundation, Inc. A Study of the Quality of Health Care in Florida's Short-Term Penal Institutions. [22] The major intent of this study was to define the resources required to effectively meet the various health care needs of Florida's short-term institutions and youth detention centers. Staff reported that the amount of care available at facilities surveyed varied directly with the medical resources of nearby communities as well as the ability and willingness of the jailer to carry out prescribed treatment. Basic areas in need of improvement were: diagnosis and the determination of need versus want; procedures for purchasing, storing, dispensing and disposing of medication; and medical records and reports.


Weisbuch, Jonathan B. "Public Health Professionals and Prison Health Care Needs," American Journal of Public Health, Vol. 67. Has been the subject of much concern for over 150 years, few constitutional rights through Civil Rights Actions. Most health services with a variety of providers, in numerous institutions. Deficiencies in the Weisbuch, due to: (1) responsibility for providing health care. Reluctance to interfere with a budgetary deficit. Plan medical services with a variety of providers, in numerous institutions. Deficiencies in the Weisbuch, due to: (1) responsibility for providing health care for prisoners. To: (2) maintain the availability of services; and (2) authority. Major constraints against change were viewed as: prisoners' access to a full array of health care services; and organized health care system with qualified health care providers. In addition, a single health service would allow for effective fiscal monitoring and result in lower costs per inmate.

Whalen, Robert P. and Lyons, John J.A. "Medical Problems of 500 Prisoners on Admission to a County Jail," Public Health Reports, the results of screening 500 prisoners detained more than 48 months. A total of 113 prisoners (22.6% of the surveyed authors) concluded that the medical problems of prisoners in services were needed.

Zalman, Marvin. Prisoners' Rights to Medical Care, Northwestern University School of Law, 1972.
APPENDIX A:

HEALTH CARE STANDARDS FOR CORRECTIONAL INSTITUTIONS

Sources for Crosstabulation:

American Medical Association - Program to Improve Medical Care and Health Services in Jails, Standards for the Accreditation of Medical Care and Health Services in Jails, Confidential draft, undated;


Law Enforcement Assistance Administration - Edward M. Brecher and Richard D. Della Penna, M.D., Health Care in Correctional Institutions, Washington: U.S. Dept. of Justice (LEAA), September, 1975; and

American Correctional Association - Commission on Accreditation for Corrections, Proposed Standards for Adult Long-Term Institutions, Confidential draft, July, 1977 (to be published in October, 1977).

Areas Covered:

- Preliminary Health Evaluations
- Comprehensive Health Evaluations
- Emergency Services
- Mental Health Care
- Dental Care
- Pharmaceuticals
A. Each individual committed to an institution of incarceration or detention, should receive a reception health evaluation and no person shall be admitted who is not conscious.

### Minimum Elements of Evaluation

A printed screening form approved by the responsible physician is used to record receiving screening information which, minimally done, includes inquiry into:

- Current illnesses and health problems including medications taken, special health requirements;
- Screening of other health problems designated by the responsible physician;
- Behavioral observation, including state of consciousness and mental status;
- Notation of body deformities, trauma markings, bruises, lesions, ease of movement, jaundice, etc.;
- Condition of the skin and body orifices, including infestations; and

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<th>JAMA</th>
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<th>LEAA</th>
<th>ACA</th>
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<tr>
<td>1.007. Receiving screening is performed on all inmates immediately upon admission to the jail and before being placed in the general population or other housing area.</td>
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<td>1.008. A printed screening form approved by the responsible physician shall include:</td>
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<td>1. Measuring of the blood pressure, respiratory rate, temperature, and pulse;</td>
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<td>2. Inquiry about: headaches, recent head injury and loss of consciousness; use of prescribed medicines; chronic health problems; regular use of habituating, sedatives, opiates, alcohol, and non-prescribed drugs; unusual bleeding or discharge; recent fever of chills; unusual pains and recent injury; allergy to medications and other substances; lacerations, bruises, abscesses, ulcers and lichen;</td>
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<td>3. A visual inspection for signs of trauma, recent surgery, abscesses, upon wounds; parenteral drug use; jaundice, persistent and communicable diseases;</td>
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### NOT ADDRESSED

- American Medical Association, APHA, American Public Health Association; LEAA, Law Enforcement Assistance Administration; and ACA, American Correctional Association.
# Cross Tabulation of Standards Relating to Health Care: Preliminary Health Evaluations, continued

<table>
<thead>
<tr>
<th>AWA</th>
<th>APHA</th>
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<tbody>
<tr>
<td><strong>Disposition/referral of inmates to qualified medical personnel on an emergency basis.</strong>&lt;br&gt;4. Observation and evaluation of consciousness, awareness of surroundings and events, and appropriateness of personal interactions as well as height and weight and gross body composition;</td>
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<td>5. Physical assessment of: head; ears; nose; eyes; chest; abdomen; genitals; and extremities;</td>
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<td>6. Implantation of tuberculosis skin test where not contraindicated; and</td>
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<td>7. Obtaining urine for the detection of glucose, ketones, blood protein and serum for serology.</td>
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<td><strong>NOT ADDRESSED</strong>&lt;br&gt;The initial health assessment of women shall also include:&lt;br&gt;1. Inquiry about: menstrual cycle and unusual bleeding; the current use of contraceptive medications; the presence of an I.U.D.; breast masses and nipple discharge; and pregnancy;</td>
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<td>2. Physical assessment: a pelvic examination; and a breast examination; and</td>
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<td>3. Specimens collected shall include a culture for gonorrhea, a pap smear, and a serological test for syphilis.</td>
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AWA- American Medical Association; APHA- American Public Health Association; LEAA- Law Enforcement Assistance Administration; and ACA- American Correctional Association
The health appraisal data collection is completed for each inmate within 14 days after admission to the jail. It includes:

- Review of earlier receiving screening;
- Additional data to complete the medical history;
- Laboratory work to detect communicable diseases including venereal diseases and tuberculosis;
- Height, weight, pulse, blood pressure and temperature;
- Other tests and examinations as appropriate; and
- Standardized physical, mental and dental examination adapted to the local situation.

The collection of health history and vital signs is performed by medically trained personnel or qualified medical personnel.

The procedures necessary to complete the evaluation shall include:

1. Inquiry about prior significant illnesses and hospitalization; familial and domiciliary diseases of significance; immunization status; current systems and abnormalities in the nervous, gastrointestinal, respiratory, auditory, integumentary, endocrine, cardiovascular, opthalmic, musculoskeletal, and blood forming systems;

2. Physical inspection and examination of organs and structure of the head, neck, chest, abdomen, genitalia, rectum, and extremities with particular emphasis and comment about the presence or absence of abnormalities suggested by the previously obtained history;

3. Mental health screening and evaluation which shall be conducted by a health worker sensitive to the crisis state in which the new prisoner is liable to be; include, as a minimum, the following elements of personal history - mental illness, mental health treatment, education, work, social, sexual, family, drug and alcohol use, and assessment of coping mechanisms and ego strengths; be documented in writing in a standardized fashion; include

A medical history should be taken within 48 hours of admission if possible, and within a week at any rate. The history can be recorded by a physician’s assistant, nurse or other health care worker provided the staff member is trained in taking medical histories.

A complete physical examination should record pertinent negative as well as positive findings; if there is a history of hepatitis, the record should show whether the liver is or is not enlarged or tender. While the physical examination should be thorough, it should cover no more ground than necessary.

Using the medical history and physical examination as guides, the physician can then determine what additional studies are needed for the evaluation of the inmate’s health status and needs. A skin test for tuberculosis should be given all newly admitted inmates, and chest X-rays thereafter, if indicated. A full range of prediagnostic services should be available to the physician - and to his patients - when needed, either within or outside of the institution.

AMA - American Medical Association; APHA - American Public Health Association; LEAA - Law Enforcement Assistance Administration; and ACA - American Correctional Association
CROSSTABULATION OF STANDARDS RELATING TO HEALTH CARE: Comprehensive Health Evaluation, continued

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<tr>
<td>1014</td>
<td>The review of all physical examination and test results and the identification of problems is performed by a physician or his/her designated qualified medical personnel and recorded on the health data form.</td>
<td>explanation to the new prisoner of the mental health services available and procedure(s) for application; 4. Collective specimens for hepatitis screening, white blood cell count, hematocrit, and other indicated tests; 5. Vision testing with Snellen Chart and auditory testing with a reliable standard; and 6. Immunization with Td in current needle users.</td>
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<tr>
<td>1025 The jail provides 24-hour emergency medical care availability. The written plan approved by the responsible physician outlines:</td>
<td>F. Each correctional institution shall provide for the emergency health needs of inmates, staff, and visitors both individually and collectively.</td>
<td>2. Every correctional institution should consult with a nearby Red Cross chapter on first-aid training opportunities for correctional personnel. First-aid supplies should be available at key points throughout the institution and shall be suitably marked and publicized.</td>
<td>3202 The institution has an arrangement with an outside licensed medical facility to provide emergency services and major surgical services on a 24-hour-a-day basis.</td>
</tr>
<tr>
<td>Arrangements exist for the use of one or more designated hospital emergency zones or other appropriate health facilities.</td>
<td>1. Each correctional institution shall have a written plan for emergency procedures. The plan shall include the range of services available within the institution and shall be investigated with existing regional emergency medical care resources.</td>
<td>3. The correctional staff should be firmly indoctrinated in the one decision they can properly make when an inmate calls for odd-hour emergency care - whether to summon medical assistance or take the inmate to the medical area.</td>
<td>3203 Written policy and procedures provide for the prompt notification of an inmate's next of kin in case of serious illness or major surgery.</td>
</tr>
<tr>
<td>Arrangements have been made for the use of an emergency medical vehicle.</td>
<td>2. All health staff persons shall be well trained in the provision of first aid and emergency care measures and cardiopulmonary resuscitation.</td>
<td>3.7 In emergencies, the senior member of the health care staff present at the moment, or a responsible member of the correctional staff, should have power to authorize immediate hospitalization.</td>
<td>3204 Written policy and procedures specify that, in the event of an inmate's death, the chief executive officer and the inmate's next of kin are notified immediately.</td>
</tr>
<tr>
<td>Jail personnel responsible for each shift are fully informed about emergency care procedures, as evidenced by prominent displaying of the plan.</td>
<td>3. Emergency equipment and supplies consistent with the written emergency procedure and commensurate with the service capability of the institution shall be available and readily accessible. First-aid supplies shall be located in all areas where accidents are likely to occur.</td>
<td>3.8 Written plans also specify the method and route of transporting to the hospital from any location in the institution.</td>
<td>3303 Personnel who have received training in emergency first-aid procedures are available on each shift.</td>
</tr>
<tr>
<td>1026 The decision of the emergency nature of illness or injury and the rendering of &quot;first aid&quot; and resuscitation is based on written guidelines and training of staff.</td>
<td>4. Medical criteria alone shall dictate whether or not an inmate shall be transferred out of the facility to a civilian health center for emergency care.</td>
<td>3304 These plans provide for emergency medical care at any location of the institution; these plans also specify the method and route of transporting to the hospital from any location in the institution.</td>
<td>3305 Personnel who have received training in emergency first-aid procedures are available on each shift.</td>
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<tr>
<td>1027 There are written guidelines for the notification of next of kin or legal guardian in case of serious illness, accident or injury.</td>
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APA = American Medical Association; APHA = American Public Health Association; LEAA = Law Enforcement Assistance Administration; and ACA = American Correctional Association
CROSSTABULATION OF STANDARDS RELATING TO HEALTH CARE: Mental Health Care

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<td>1040 Written guidelines approved by the responsible physician outline procedures for the implementation of the screening, referral and care of the mentally ill or deficient inmates:</td>
<td>Mental health services should be made available at every correctional institution. The State (jurisdiction) may not mandate treatment for any individual, unless a person, by reason of mental disability poses a clear and present danger of grave injury to himself or others. Then, and only then, intervention may be mandated, but only with the least drastic measures and only after civil judicial direction by the appropriate court, in which the individual is accorded an independent psychiatric evaluation and due process of law.</td>
<td>NOT ADDRESSED</td>
<td>3307.02 Written policy and procedure govern the treatment of inmates with severe emotional disturbances.</td>
</tr>
<tr>
<td>The responsible physician has provided a written list of symptoms indicative of mental illness;</td>
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<td>3307.03 Where there are separate living units for inmates with severe emotional disturbances, an interdisciplinary team is assigned to these living units.</td>
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<td>Personnel are trained regarding recognition of symptoms of mental illness; and</td>
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<td>3307.04 Written policy specifies that appropriate facilities are available for inmates who are diagnosed by qualified psychiatrists or psychologists as severely psychotic.</td>
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<td>Specific referral resources are outlined.</td>
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<td>3307.06 Psychiatric consultation is available for the management and treatment of inmates with special needs.</td>
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<td>1041 Admission to appropriate health facilities in lieu of jailing is sought for suspected mentally ill or deficient inmates for whom outpatient treatment is not possible.</td>
<td>Mental health professionals who participate in administrative decisions such as parole and furlough should be other than those mental health professionals providing direct therapeutic services to the inmate.</td>
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APA= American Medical Association; APHA= American Public Health Association; LEAA= Law Enforcement Assistance Administration; and ACA= American Correctional Association.
Full confidentiality of all information obtained in the course of treatment should be maintained at all times with the only exceptions being the normal legal and moral obligations to respond to a clear and present danger of grave injury to the self or others, and the single issue of escape. Direct treatment services should be provided in a context of varied modalities. The following direct treatment services shall be made available as a minimum:

1. Crisis intervention;
2. Brief and extended evaluation/assessment;
3. Short-term therapy - group and individual;
4. Long-term therapy - group and individual;
5. Therapy for family and significant others;
6. Counseling shall be available for all inmates;
7. Medication - prescribed in accordance with generally accepted pharmacological principles;

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<td>3. Short-term therapy - group and individual;</td>
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<td>4. Long-term therapy - group and individual;</td>
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<td>5. Therapy for family and significant others;</td>
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<td><strong>1032</strong> There are written guidelines approved by the responsible physician outlining the availability of 24-hour emergency dental care.</td>
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<td><strong>NOT SPECIFICALLY ADDRESSED</strong> - the authors of the standards recommended a separate study of dental care in institutions be undertaken.</td>
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<td><strong>1034</strong> Dental screening of each inmate within 14 days of admission will include charting decayed, missing and filled teeth and taking a dental history for the purposes of identification. It can be performed by medically trained personnel.</td>
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<td>NOT ADDRESSED</td>
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<tr>
<td><strong>1035</strong> Dental Prevention services for each inmate will be provided within 14 days of admission to the jail. Dental prevention includes instruction of tooth brushing, flossing, saliva and mouth rinses and spit directions. It can be performed by medically trained personnel.</td>
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<td><strong>1036</strong> Dental examination of each inmate within three months of admission will include: a complete examination noting the external and internal structure of the mouth; abnormal function, discoloration of the mucous membrane and gums; and diseases of the teeth and supporting structures; diagnostic x-rays when deemed essential; and testing, if applicable, of the pulp,</td>
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<tr>
<td><strong>C. Dental Care - Dental assessment:</strong> Each inmate should have a dental assessment on admission to identify acute problems.</td>
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<td>• The dental assessment shall be performed by a dentist or a dental hygienist on all resident inmates.</td>
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<td>• The assessment shall include clinical examination, charting and a history from which should be derived a treatment plan for correction of dental defects, dental habits and improper dental attitude.</td>
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<td>• The dental assessment shall classify individuals according to the priority of treatment needs and the time frame into which that individual is detained in terms of length of stay. All correctional institutions should provide for the care of dental emergencies, non-emergency dental conditions and recall, depending on the duration of the inmate's stay. Services shall include the following:</td>
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<td>• An oral profile which shall include the number of fractured teeth, mobile teeth, erupted and unerupted teeth, the type of dentition, the type of occlusion and any present or past trauma to</td>
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**AMA - American Medical Association; APHA - American Public Health Association; LEAA - Law Enforcement Assistance Administration; and ACA - American Correctional Association**
CROSSTABULATION OF STANDARDS RELATING TO HEALTH CARE: Dental Care, continued

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<td>Susceptibility of caries,</td>
<td>the maxilla or mandible; the</td>
<td>American Medical Association;</td>
<td>American Public Health</td>
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<td>cancer smear and diagnostic</td>
<td>types and location of fillings in</td>
<td>Association; LEAA- Law</td>
<td>Association; and ACA- American</td>
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<tr>
<td>past. It can be performed by</td>
<td>the teeth, diastema, condition of</td>
<td>Enforcement Assistance</td>
<td>Correctional Association</td>
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<tr>
<td>qualified medical personnel.</td>
<td>frenula, size and shape of the</td>
<td>Administration; and ACA- American</td>
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<td>037 Dental treatment will be</td>
<td>tongue, the color of tissues,</td>
<td>Correctional Association</td>
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<td>initiated on inmates within 3</td>
<td>presence or absence of tumors and</td>
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<td>months after admission to the</td>
<td>lesions of the soft and hard</td>
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<td>jail, when the health of the</td>
<td>tissues, speech impediment, and</td>
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<td>inmate patient would otherwise</td>
<td>anesthesia;</td>
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<td>be adversely affected. Dental</td>
<td>Preventive dentistry shall</td>
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<td>treatment includes oral prophylaxis,</td>
<td>include plaque evaluation,</td>
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<tr>
<td>restorative dentistry, periodontics and oral surgery;</td>
<td>plaque identification and control,</td>
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<td>periodontics and extractions.</td>
<td>fluoride treatment and counseling including information on oral hygiene;</td>
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<td>It is performed by a dentist.</td>
<td>As a minimum, the restoration of the dental apparatus to adequate masticatory function will be provided;</td>
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<tr>
<td>038 All dental care is provided under the direction and supervision of a dentist licensed in the state.</td>
<td>Minor oral surgery (routine extraction);</td>
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<tr>
<td>039 Dental prosthetics are provided when the health of the inmate patient would otherwise be adversely affected.</td>
<td>Periodontics; and</td>
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<td></td>
<td>General recall and maintenance.</td>
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The medications and those subject to abuse is recorded in a manner and on a form approved by the responsible physician. The person administering medications does so under the charge of the jailor and a form approved by the responsible physician concerning the dispensing of these medications. The person administering medications does so under the charge of the jailor and a form approved by the responsible physician. A written policy and procedure ensure that inmates receive all medication prescribed by a physician when they are temporarily off the prison grounds or in administrative segregation or disciplinary detention.

Each correctional institution shall designate a secure area for the storage of all medications. Every institution shall have access to the professional services of a pharmacist who will provide the regular and general supervision of pharmacy activities; approve all pharmacy activities; and approve all pharmacy related procedures and shall provide monitoring of drug therapy and the overall pharmacy program. Each statewide correctional system should have a statewide pharmacy and Therapeutic Committee to prepare and periodically review the medication formulary, and to audit drug utilization throughout the correctional system.

Prescription practices must be as uniform as possible throughout the institution. Consultants unfamiliar with institutional conditions should be able to recommend rather than prescribe a drug regimen; the actual prescribing should be done by a staff physician in accordance with the institution’s uniform policy. No prescription in a correctional institution should be refillable. A limited number of doses should be prescribed, and the results should be evaluated before a new prescription is written. A prescription should not be handed

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<td><strong>AMA</strong></td>
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<tr>
<td>1. Each correctional institution shall designate a secure area for the storage of all medications.</td>
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<tr>
<td>2. In those facilities in which an actual pharmacy exists, it shall be physically separate from other activities.</td>
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<tr>
<td>3. Every institution shall have access to the professional services of a pharmacist who will provide the regular and general supervision of pharmacy activities; approve all pharmacy activities; and approve all pharmacy related procedures and shall provide monitoring of drug therapy and the overall pharmacy program.</td>
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<tr>
<td>4. Non-prescriptive (over-the-counter) medications may be made available in the correctional institution at places other than the health services facility after consultation with the health care staff. Specific written rules governing the dispensing of these medications shall be available.</td>
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<tr>
<td>2. A pharmacy must operate under the continuing supervision of a registered pharmacist and be inspected periodically by the state’s pharmacy-licensing agency. Medications may not be used in any pharmacy capacities and should not be dispensed by any pharmacy unless authorized.</td>
</tr>
<tr>
<td>Each statewide correctional system should have a statewide Pharmacy and Therapeutic Committee to prepare and periodically review the medication formulary, and to audit drug utilization throughout the correctional system.</td>
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<td>1056 The medications form becomes a part of the inmate's medical record.</td>
<td>Inclusion in the medical record, medications not administered shall be accounted for and returned to the pharmacy daily. Where size of the facility does not warrant sufficient health services staffing for administration of all medication, such administration may be carried out by adequately trained personnel by sealed single dose packages, delivered daily, adequately identified and labeled with directions.</td>
<td>To the inmate, but should be forwarded to the pharmacy through secure channels to prevent tampering.</td>
<td>A &quot;drug profile&quot; should be maintained for each inmate, showing all drugs prescribed for him.</td>
</tr>
<tr>
<td>1057 All controlled substances, syringes, needles and surgical instruments are inventoried weekly.</td>
<td>Medications not administered shall be accounted for and returned to the pharmacy daily. Where size of the facility does not warrant sufficient health services staffing for administration of all medication, such administration may be carried out by adequately trained personnel by sealed single dose packages, delivered daily, adequately identified and labeled with directions.</td>
<td>The medication line or &quot;pill line&quot; for the dispensing and administering of drugs should be held at a different time in a different place than sick call. The medication line should be surrounded by adequate security precautions.</td>
<td></td>
</tr>
<tr>
<td>1058 All controlled substances, syringes, needles and surgical instruments are stored under maximum security conditions.</td>
<td>6. When available, liquid forms of medications shall be utilized.</td>
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